**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| **In the Matter of the Accusation Against:** | ) | |
| **MOHAMMAD ASHORI, M.D.** | ) | **Case No. 800-2018-046068** |
| **Physician's and Surgeon's Certificate No. A97831** | ) | **OAH No. 2018120246** |
| **Respondent** | ) | |

## DECISION

**The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on May 24, 2019.**

**IT IS SO ORDERED April 25, 2019.**

**MEDICAL BOARD OF CALIFORNIA**

**By:** Ronald H Lewis, MD

**Ronald Lewis, M.D., Chair**
**Panel A**

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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|---|---|
| In the Matter of the Accusation Against:<br><br>MOHAMMAD ASHORI, M.D.,<br>Physician's and Surgeon's Certificate<br>No. A 97831<br><br>Respondent. | Case No. 800-2018-046068<br><br>OAH No. 2018120246 |

# PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on March 7, 2019, in Oakland, California.

Deputy Attorney General Carolyne Evans represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Respondent Mohammad Ashori, M.D., was present for the hearing representing himself.

The matter was submitted for decision on March 7, 2019.

## FACTUAL FINDINGS

1. Respondent Mohammad Ashori, M.D., received Physician's and Surgeon's Certificate No. A 97831 on October 25, 2006. As of August 13, 2018, this certificate was active, and was scheduled to expire April 30, 2020. Because of the order described more fully below in Finding 6, the Board suspended respondent's authority under this certificate to practice medicine in California between August 13, 2018, and August 30, 2018.

2. On October 31, 2018, acting in her official capacity as Executive Director of the Medical Board of California (Board), complainant Kimberly Kirchmeyer filed an accusation against respondent. The accusation alleges that the Oregon Medical Board entered an order, effective July 12, 2018, imposing professional discipline against respondent in Oregon. Because of this Oregon order and the events that led to it, complainant seeks a disciplinary order against respondent in California. Respondent requested a hearing.

*Professional Experience and Certificate History*

3. Respondent is trained in family medicine. He held specialty certification from the American Board of Family Medicine until December 2018.

4. In addition to his California physician's and surgeon's certificate, respondent also holds licenses to practice medicine in Oregon and in Washington. He lives in Oregon.

5. The evidence did not establish respondent's entire medical practice history. In May 2017, respondent worked both in a medical marijuana clinic and in a Kaiser Permanente urgent care clinic. In recent years he also has provided telemedicine services.

6. Effective July 12, 2018, the Oregon Medical Board entered an order imposing professional discipline on respondent. The Oregon Medical Board made this order because of the incident and investigation described more fully below in Findings 8 through 18. The order:

a. Reprimanded respondent;

b. Required respondent to pay a $5,000 civil penalty; and

c. Suspended respondent from practicing medicine in Oregon for 30 days, beginning August 1, 2018.

7. The Washington Medical Commission also has imposed professional discipline on respondent, because of the Oregon Medical Board discipline described in Finding 6. A document memorializing this disciplinary order was not in evidence. Respondent described the order as requiring a $100 fine, a 1,000-word essay, and annual meetings with the Washington Medical Commission over a period he did not specify.

*Incident Leading to Disciplinary Action in Oregon*

8. In May 2017, one of respondent's medical marijuana clinic colleagues mentioned to him that she recently had experienced occasional heartbeat irregularity and that her regular healthcare provider had recommended an electrocardiogram (EKG). The healthcare provider had not performed the EKG, however, and the colleague was unsure how or where she might have the test.

9. Respondent, this colleague, and another colleague already had made plans to socialize that evening after work. Respondent suggested that on the way to their social engagement, they could stop by the Kaiser Permanente urgent care clinic where respondent also sometimes worked for the co-worker to have her EKG. Respondent's colleagues agreed to this plan.

10. Respondent suggested this course of action because he knew that the urgent care clinic had EKG equipment, that clinic staff members performed EKG's regularly, and that an EKG is a relatively quick procedure. Respondent himself did not know how to use the EKG equipment, but at the time he regularly interpreted EKG reports.

11. Respondent's colleague was not a Kaiser Permanente member, and had never before received care at the Kaiser Permanente urgent care clinic. She did not have a Kaiser Permanente medical record.

12. Several people were waiting for service at the urgent care clinic when respondent and his colleagues arrived. Respondent used his employee badge to escort his colleague past the reception desk. He asked a registered nurse to help him arrange for his colleague to have an EKG, but the nurse objected that the colleague needed to check in to the clinic and wait her turn. The nurse also told respondent that she was not sure how to do an EKG.

13. Respondent discussed the matter with the registered nurse, and with a licensed practical nurse who joined their conversation. The nurses agreed to do the EKG without making respondent's colleague wait or check in.

14. Respondent was not present in the examination room when the nurses performed his colleague's EKG, but the Oregon Medical Board found that they used an Internet search to confirm where to place the EKG electrodes. The nurses did not record the colleague's name or vital signs, and did not produce any formal medical records for the colleague. They did produce an EKG report.

15. Respondent reviewed the EKG report briefly and told his colleague that it "looked fine." The evidence did not establish what respondent then did with the EKG report, except that he did not save any copy of it in any Kaiser Permanente patient record for the colleague. Respondent and his colleagues then continued on to their social engagement.

16. The next day, respondent praised the urgent care clinic staff members who had assisted him and his colleagues to the staff members' supervisor. The supervisor opened an internal investigation into the incident; the investigation prompted a report to the Oregon Medical Board.

17. When an Oregon Medical Board investigator first contacted respondent about the incident, he was on a two-month overseas trip. In a letter dated September 25, 2017, the investigator asked respondent to name the two medical marijuana clinic colleagues who had come to the urgent care clinic with him. Respondent responded to the investigator before returning to the United States, but declined to name the colleagues because he believed they wished to protect their own privacy.

18. The Oregon Medical Board investigator wrote again to respondent requesting the colleagues' names, and identifying the Oregon statutes on which the investigator relied for this request. Respondent delayed a few more weeks (during which time he consulted counsel) before finally naming the colleagues at an investigation interview on November 17, 2017. In total, about seven weeks passed between the time respondent first became aware that the investigator wanted to know his colleagues' names and the time respondent provided those names.

19. After the investigation, and upon respondent's stipulation, the Oregon Medical Board entered the order described above in Finding 6. The order found that respondent had acted unprofessionally by assisting his colleague with the EKG, and that he had failed to cooperate in the Oregon Medical Board's investigation by withholding his colleagues' names from the investigator.

*Additional Evidence*

20. Respondent no longer works at the Kaiser Permanente urgent care clinic and believes that the clinic staff members who assisted him and his colleague also lost their jobs.

21. In spring 2018, respondent completed a professional boundaries course through the Physician Assessment and Clinical Education program at the University of California, San Diego. He has not taken any other special courses relating to the errors that led to his Oregon discipline, such as a medical recordkeeping course, a course about EKG's, or a professional ethics course.

22. Respondent testified credibly that when he asked the nurses at the Kaiser Permanente urgent care clinic to help him and his colleague, he considered his request as one for a quick personal favor. He did not invoke, or intend to use, his superior position in the clinic's medical hierarchy to bully the nurses. He realizes now, however, that the power differential between himself and the nurses probably influenced the nurses' decision to depart from clinic protocol and from sound medical and nursing practice.

23. Respondent also testified, again credibly, that when he offered to help his colleague get an EKG, he did not consider himself to have assumed responsibility for her care. In particular, he did not consider the possibility that his colleague might rely to her detriment on his off-the-cuff interpretation of the result rather than taking it back to her regular healthcare provider for further discussion. He realizes now that he did create this risk, and that he should not have offered to participate personally in his colleague's medical care simply as a shortcut.

24. The Oregon Medical Board's investigation, described above in Findings 17 and 18, is the only similar investigation respondent ever has undergone. Until he had consulted counsel, after returning from his trip, he did not understand the extent of his responsibility to cooperate in that investigation.

25. Respondent maintains an Internet blog, on which he writes about his professional experiences and exchanges comments with readers. In a blog entry first published November 12, 2017, respondent described his experience during the Oregon Medical Board's investigation. In response to a reader's question asking why he was under investigation, respondent stated in April 2018, "I ordered an EKG for a friend and the nurse never had the patient check in or get charged for it." At the hearing, however, respondent affirmed that he understands now that his error was more serious than simply helping his friend skip the waiting room or avoid expense, and that he rather than either of the urgent care nurses was responsible for that error.

26. In a blog entry first published November 7, 2018, respondent described his experience attempting to resume employment in telemedicine after the Oregon suspension described above in Finding 6.c and the California suspension described above in Finding 1. He used an informal tone, and expressed frustration with several obstacles he had encountered but had not expected. Despite this frustration, respondent's blog entry did not imply that respondent would be likely to repeat the misconduct that led to his Oregon professional discipline.

## LEGAL CONCLUSIONS

1. The Board may impose professional discipline on respondent if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Unprofessional conduct includes conduct occurring in another state and constituting cause for professional discipline in that state, if such conduct also would constitute cause for discipline in California. (Bus. & Prof. Code, §§ 141, 2305.) The matters stated in Findings 6 and 8 through 18 constitute cause for discipline against respondent.

*Disciplinary Considerations*

3. The matters stated in Findings 1 and 6 establish that respondent already has served practice suspensions in California and Oregon. The matters stated in Finding 21 establish that respondent has taken a relevant course; and the matters stated in Finding 20 and 22 through 26 show that respondent poses no unusual risk of future misconduct.

4. Discipline in California because of discipline in another state is discretionary, not mandatory. (Bus. & Prof. Code, § 2227, subd. (a).) Under all these circumstances, a reprimand is appropriate; but the burden and expense both to respondent and to the Board of probation is not necessary to protect California medical consumers.

## ORDER

Physician's and Surgeon's Certificate No. A 97831, issued to respondent Mohammad Ashori, M.D., is hereby publicly reprimanded.

DATED: March 26, 2019

DocuSigned by:
Juliet E. Cox
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JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 31 2018
BY Silvia Pasion ANALYST

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**Mohammad Ashori, M.D.**<br>**20 NW. 16th Ave., #205,**<br>**Portland, OR 97209-2626**<br><br>**Physician's and Surgeon's Certificate No. A 97831,**<br><br>Respondent. | Case No. 800-2018-046068<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 25, 2006, the Board issued Physician's and Surgeon's Certificate Number A 97831 to Mohammad Ashori, M.D. (Respondent). The Physician's and Surgeon's

Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed. On August 13, 2018, the Board issued a full suspension no practice order pursuant to Business and Professions Code Section 2310 (a). On August 30, 2018, the Board vacated the suspension order by operation of law.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides, in part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code provides that the Board shall take action against a licensee who is charged with unprofessional conduct.

6. Section 2305 of the Code states:

"The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

7. Section 141 of the Code states:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state,

an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

## CAUSE FOR DISCIPLINE

**(Discipline, Restriction, or Limitation Imposed by Another State)**

8. On or about July 12, 2018, the Oregon Medical Board issued a Stipulated Order (Oregon Order). The Oregon Order found that Respondent engaged in unprofessional conduct. The circumstances are as follows:

9. In May of 2017, Respondent worked occasional clinical shifts at the Kaiser Permanente Urgent Care Clinic [Kaiser Clinic] in Portland and also worked as a physician at the Aurora Clinic (a medical marijuana clinic).

10. One day while at work in the Aurora Clinic in early May 2017, a female co-worker, Patient A, informed Respondent that she had been recently having episodic heart palpitations and that her nurse practitioner told her that she needed to have an electrocardiogram (EKG) done. Patient A did not know what to do. In response, Respondent invited Patient A and another female co-worker to accompany him to the Kaiser Clinic after work to get the EKG done, and afterwards, they could go to a bar for drinks. (Respondent was not scheduled to perform a clinical shift at Kaiser Clinic that day).

11. At the end of their work day at the Aurora Clinic, Respondent and Patient A and a female co-worker drove to the Kaiser Clinic and entered the waiting room of the urgent care clinic, which was crowded with patients waiting to be seen. Respondent escorted Patient A and the co-worker past the check-in desk, and used his Kaiser badge to open the security door, and escorted them both into the clinic area.

12. Respondent subsequently approached the Kaiser Clinic's nurses' station and asked the on-duty Registered Nurse (RN) to perform an EKG on Patient A because she was

experiencing heart palpitations. Patient A was not registered with Kaiser as a patient, and had not been checked in at the front desk. The RN protested that Patient A needed to be checked in, that she did not do EKGs, and did not recall from her early training how to perform an EKG.

13. Respondent told the RN that EKGs were easy to perform and urged her to proceed. Respondent escorted Patient A and his other co-worker into a clinic examination room, and left the room. The RN did not record Patient A's name nor record her vital signs. The RN, assisted by a licensed practice nurse (LPN) accessed Google on their cell phones to determine where to place the electrodes, and subsequently attached electrodes to Patient A. The EKG was turned on and a tracing was produced and printed.

14. Respondent inspected the EKG print-out and informed Patient A that she "looked fine." Respondent left the Kaiser Clinic accompanied by Patient A and his other co-worker and subsequently went to a bar for drinks. No patient record was ever created to record the event at the Kaiser Clinic and the EKG record was not retained. The Oregon Medical Board found that Respondent's conduct with respect to Patient A constituted "an improper physician-patient relationship that was contrary to recognized standards of ethics."

15. On or about September 25, 2017, the Oregon Medical Board asked Respondent to identify the two females he brought to the Kaiser Clinic. Respondent declined to provide this information.

16. On or about October 26, 2017, the Oregon Medical Board notified Respondent that he was compelled by statute to provide the identities of the two females he brought to the Kaiser Clinic. Respondent replied to the Oregon Medical Board that he had reviewed the statute and was not willing to provide the requested information. It was not until November 17, 2017, when the Oregon Medical Board's investigative staff conducted an in-person interview with Respondent, that he finally revealed the requested names. The Oregon Medical Board found that Respondent's refusal to timely provide the identities of the two females subjected him to discipline for failing to comply with a Board request.

17. As a result of Respondent's unprofessional conduct, the Oregon Medical Board issued a letter of reprimand to Respondent, ordered him to pay a civil penalty of $5000.00, and suspended him from the practice of medicine in Oregon for 30 calendar days.

18. Respondent's conduct as set forth above in paragraphs 8 through 17, and the actions of the Oregon Medical Board, as set forth in the Oregon Medical Board Order, constitute unprofessional conduct within the meaning of section 2305 and conduct subject to discipline within the meaning of section 141(a). The Oregon Medical Board Order is attached as Exhibit A.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 97831, issued to Mohammad Ashori, M.D.;

2. Revoking, suspending or denying approval of Mohammad Ashori, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mohammad Ashori, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:
October 31, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

# EXHIBIT A

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

| | | |
|---|---|---|
| In the Matter of<br><br>MOHAMMAD ASHORI, MD<br>LICENSE NO. MD170360 | ) | STIPULATED ORDER |

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Mohammad Ashori, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On April 5, 2018, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include up to the revocation of license, a $10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(17) willful violation of any rule adopted by the board, board order, or failing to comply with a board request pursuant to ORS 677.320.

3.

Licensee is a board-certified family physician practicing medicine in Portland, Oregon. Licensee's acts and conduct that violated the Oregon Medical Practice Act follow:

3.1 In early May of 2017, Licensee worked occasional clinical shifts at the Kaiser Permanente Urgent Care Clinic [Kaiser Clinic] in Portland and also worked as a physician at the Aurora Clinic (a medical marijuana clinic). One day while at work in the Aurora Clinic in early May 2017, a female co-worker, Patient A, informed Licensee that she had recently been having episodic heart palpitations and that her nurse practitioner told her that she needed to have an

EKG done. Patient A did not know what to do. In response, Licensee invited Patient A and another female co-worker to accompany him to the Kaiser Clinic after work to get the EKG done, and afterwards, they could go to a local bar for drinks. (Licensee was not scheduled to perform a clinical shift at the Kaiser Clinic that day.) At the end of their work day, Licensee and the two co-workers drove to the Kaiser Clinic and entered the waiting room of the Urgent Care Clinic, which was crowded with patients waiting to be seen. Licensee escorted the co-workers past the check-in desk, and using his pass badge to open the security door, escorted the two co-workers into the clinic area. Licensee subsequently approached the nurses' station and asked the on-duty Registered Nurse (RN), to perform an electrocardiogram (EKG) on Patient A, because she was experiencing heart palpitations. Patient A was not registered with Kaiser Permanente as a patient, and had not been checked in at the front desk. The RN protested that that patient needed to be checked in, that she didn't do EKGs, and did not recall from her early training how to perform one. Licensee told her that it was easy and urged her to proceed. Licensee escorted the two co-workers into a clinic examination room, and left the room. The RN did not record Patient A's name nor record her vital signs. The RN, assisted by a Licensed Practical Nurse (LPN), accessed Google on their cells phones to determine where to place the electrodes, and subsequently attached ten electrodes to Patient A. The electrocardiogram was turned on and a tracing was produced and printed. Licensee quickly inspected the print-out and informed Patient A that she "looked fine." Licensee subsequently left the Kaiser clinic accompanied by the two co-workers. They subsequently went to a local bar for drinks together. No patient record was created to record the events at the clinic and the EKG record was not retained. Licensee's described behavior with Patient A constituted an improper physician-patient relationship that was contrary to recognized standards of ethics.

3.2 In a letter dated September 25, 2017, Licensee was asked to submit a response to the Board. The letter requested in part, the identities of the two females he brought to the Kaiser Clinic. In his response, Licensee failed to provide this information, stating that the females did not want to be identified. On October 26, 2017, Board staff left a voicemail for the Licensee

regarding this response, informing him that he was compelled by statute to provide the requested information, and referred him to Oregon Revised Statutes 677.190 and 677.320. Licensee returned the call and in a voicemail stated that he had read the statutes and that he would not be providing the identities of the two females. It was not until November 17, 2017, when investigative staff conducted an in-person interview with Licensee that he finally revealed the requested names. Licensee's refusal to provide the requested information violates ORS 677.190(17).

4.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee admits that he engaged in the conduct described in paragraph 3 (above) and that this conduct violated ORS 677.190(1)(a) as defined in ORS 677.188(4)(a); and ORS 677.190(17). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following terms and conditions:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $5,000 in two payments. The first payment of $2,500 must be paid within 60 days from the effective date of this Order. The second payment of $2,500 must be paid within 30 days thereafter.

5.3 Licensee is suspended from the practice of medicine for 30 calendar days, effective the first day of the month following the month in which this Order becomes effective.

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5.4 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

5.5 Licensee must obey all federal and Oregon state laws and regulations pertaining to the practice of medicine.

5.6 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED THIS 30th day of May, 2018.

[redacted]

MOHAMMAD ASHORI, MD

IT IS SO ORDERED THIS 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

K. DEAN GUBLER, MD
BOARD CHAIR